

# Hospital Patient Safety News

Summer 2013

A Newsletter for Hospital Staff Participating in IPRO's Patient Safety Initiative

[www.ipro.org](http://www.ipro.org)



Welcome to the Summer 2013 issue of IPRO's *Hospital Patient Safety News*, featuring current news about healthcare-associated infections (HAI). Subscriptions to this newsletter can be requested by email to Susan Ulmer at [sulmer@nyqio.sdps.org](mailto:sulmer@nyqio.sdps.org).

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[www.surveymonkey.com/s/YL2RZZG](http://www.surveymonkey.com/s/YL2RZZG).

## News You Can Use

### Prevention and Treatment of *Clostridium difficile* Infection



Taylor Laiacona, 2013 Pharm D Candidate working with IPRO, summarizes current and advancing prevention and treatment tactics for *Clostridium difficile* infection (CDI) that healthcare facilities may apply to their practices. Her article points out that infection control and prevention of CDI requires a multifaceted approach. In addition to the use of proper personal protective gear, hand hygiene, room isolation and targeted environmental disinfection practices, antimicrobial stewardship is a highly recommended component of a CDI prevention program. To demonstrate the effectiveness of an antimicrobial stewardship program, the article references a study published by the *Journal of Antimicrobial Chemotherapy* that revealed stewardship intervention that lowered the usage of fluoroquinolones and cephalosporins while reducing the risk of CDI. The study program included development and promotion of antimicrobial use guidelines and the formation of an antibiotic management team. Ms. Laiacona's article further explains current CDI treatment guidelines that recommend metronidazole or vancomycin, based on severity of clinical criteria and infection recurrence. Finally, the article highlights research on fecal transplantation and

toxin vaccine that seems promising for future treatment and prevention of poorly responsive and recurrent CDI. To read further details on the prevention and treatment of CDI, visit [www.ipro.org/index/cms-files/system-action/hai/cdiarticle5-14-13.pdf](http://www.ipro.org/index/cms-files/system-action/hai/cdiarticle5-14-13.pdf).



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## CDC Alert - Novel Coronavirus

The Centers for Disease Control and Prevention (CDC) calls for clinicians to remain alert for the novel coronavirus causing the Middle East Respiratory Syndrome (MERS). The novel coronavirus, named in May 2013 as the Middle East Respiratory Syndrome Coronavirus (MERS-CoV), was first identified in 2012 in Saudi Arabia. Since then MERS-CoV has been found in patients in France, Italy, Jordan, Qatar, Tunisia, United Kingdom, and United Arab Emirates. Most patients with MERS experience a severe acute respiratory illness with symptoms of fever, cough, and shortness of breath. MERS has a growing mortality rate reaching over 50%. Modes of human-to-human transmission are not completely clear, but droplet and contact transmission is suspected. Infection control for those with MERS symptoms include isolation with standard, droplet, and contact precautions implemented. For the most up-to-date information and guidance on MERS, visit [www.cdc.gov/coronavirus/mers/case-def.html](http://www.cdc.gov/coronavirus/mers/case-def.html).

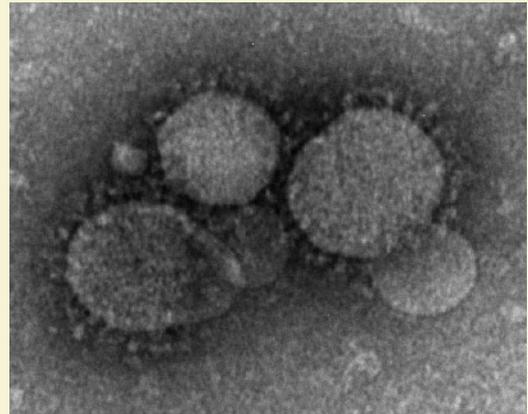


Image source: Cynthia Goldsmith/Maureen Metcalfe/Azaibi Tamim

## Steps to Success

### Hospitals Honored at IPRO's 2013 Annual Meeting

Congratulations to Beth Israel Medical Center, Canton Potsdam Hospital, Kings County Hospital Center, and St. John's Episcopal Hospital! On June 4, 2013, IPRO honored each of these facilities as recipients of the 2013 IPRO Quality Award. The awards, bestowed annually by IPRO, recognize organizations and professionals who demonstrate a commitment to improving the quality of care provided to New York's Medicare beneficiaries and Medicaid recipients.

Beth Israel was awarded for their hospital staff's ongoing participation in IPRO's educational activities, for their consistent efforts to share best practices with other hospitals participating in the Centers for Medicare & Medicaid's initiative to prevent healthcare-associated infections (HAIs) in hospitals, and their ongoing improvements in prevention of catheter-associated urinary tract infection (CAUTI) and central line-associated bloodstream infection (CLABSI).

Canton Potsdam Hospital was awarded for having maintained a rate of 0% CLABSI since January, 2011 and 0% catheter-associated urinary tract infection rate from the start of the initiative in November 2011.

The Medical Intensive Care Unit staff at Kings County Hospital Center was awarded for establishing a multi-disciplinary team dedicated to patient safety and quality improvement. The team conducted detailed root cause

analyses and implemented evidence-based interventions, leading to the elimination of CLABSIs in the unit—a 100% relative improvement rate in for this measure. The unit has not had a CLABSI in 20 months.

St. John's Episcopal Hospital was awarded for their implementation of process changes to improve patient safety, reduce infection rates, and provide quality care to their patients. Efforts included creating cross-departmental collaborations to improve performance monitoring, identify deficiencies and implement solutions; developing department-specific quality plans; redesigning their medical records system to facilitate improved data collection; and implementing an open-door policy between the infection control department and the hospital staff.



*Hospital Patient Safety News* welcomes stories from our readers. If you have a success story you would like to share in our newsletter, please contact Teré Dickson, MD, MPH at [tdickson@nyqio.sdps.org](mailto:tdickson@nyqio.sdps.org).

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## CUSP Corner

The Comprehensive Unit-based Safety Program (CUSP) offers a variety of tools and techniques to help clinical teams identify and resolve patient safety issues at the unit level. The five-step program features a structured, strategic framework for safety improvement that also empowers staff to take charge and address identified safety hazards. To learn more about CUSP visit: [www.onthecuspstophai.org](http://www.onthecuspstophai.org).

### On the CUSP: Stop CAUTI

Catheter-associated Urinary Tract Infections (CAUTI) continue to be a nationwide concern in hospital patient safety. *On the CUSP: Stop CAUTI*, a new nationwide initiative, offers an implementation guide and a variety of tools and resources to help hospitals reduce the unnecessary use of urinary catheters and ensure proper insertion, care and removal of catheters. The intervention was first tested through the 2007 statewide initiative, the Michigan Keystone: Hospital-Associated Infection project. Due to its success in achieving and sustaining 25% reduction in catheter utilization, the program was expanded into *On the CUSP: Stop CAUTI* for nationwide innovation spread by the partnership including Agency for Healthcare Research and Quality (AHRQ) the Health Research & Educational Trust (HRET), the Michigan Health & Hospital Association (MHA) Keystone Center for Patient Safety & Quality, St. John Hospital and Medical Center, the University of Michigan's Patient Safety Enhancement Program, and the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality (Armstrong Institute).

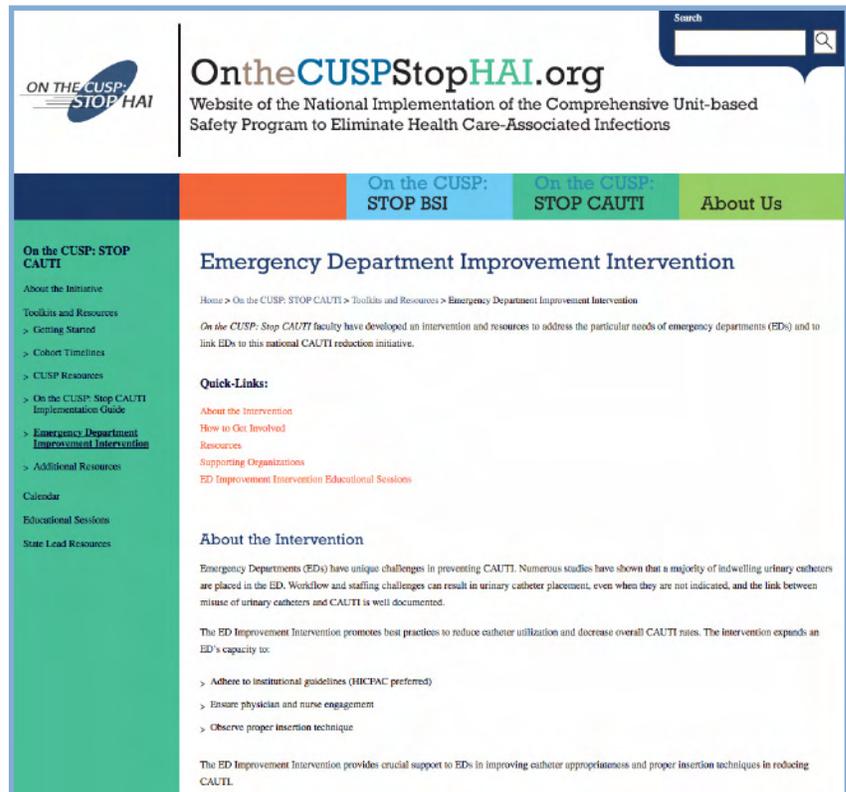
The national goals of *On the CUSP: Stop CAUTI* include:

- Reduction of mean CAUTI rates in participating clinical units by 25 percent; and
- Improvement in safety culture, as evidenced by improved teamwork and communication in disseminating the CUSP methodology.

The project also aims to:

- Promote the appropriate use of indwelling catheters;
- Improve the culture of safety, teamwork, and communication; and
- Improve proper placement technique and care of catheters.

Their website, [www.onthecuspstophai.org/on-the-cuspstop-cauti](http://www.onthecuspstophai.org/on-the-cuspstop-cauti), describes the project in full and includes information on becoming a participating hospital. All project materials are easily available for download. The implementation guide gives a step-by-step intervention guide, describing the team approach model, outlining unit project leader roles and responsibilities, detailing program management tools and resources, and defining improvement measures. Among the toolkits and resources is an emergency department-targeted intervention that addresses



the unique CAUTI prevention challenges faced in a hospital area known for high utilization of indwelling urinary catheters. Visit: [www.onthecuspstophai.org/on-the-cuspstop-cauti/toolkits-and-resources/emergency-department-improvement-intervention](http://www.onthecuspstophai.org/on-the-cuspstop-cauti/toolkits-and-resources/emergency-department-improvement-intervention).

## 5

### Five Steps of CUSP

1. Educate staff on the Science of Safety
2. Identify defects in the system
3. Engage senior leadership
4. Learn from one defect per specified time period
5. Implement teamwork tools

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## Research Briefs

Kundrapu, S., Sunkesula, V., Jury, L.A., and others (2012, October). "Daily infection of high-touch surfaces in isolation rooms to reduce contamination of healthcare workers' hands." (AHRQ grant HS20004). *Infection Control and Hospital Epidemiology* 33(1), pp. 1039–1042.

This randomized trial demonstrated that daily disinfection of high-touch surfaces in rooms of patients with *Clostridium difficile* infection and methicillin-resistant *Staphylococcus aureus* (MRSA) colonization reduced the transmission of these pathogens onto hands of those contacting high-touch surfaces. This approach also reduced contamination of hands of health care workers caring for patients.

Clancy, C. (2012). "Eliminating central line-associated blood stream infections. Progress continues on a national patient safety imperative." *Journal of Nursing Care Quality* 27(3), pp. 191–193. Reprints (AHRQ Publication No. 12-R101) are available from the AHRQ Publications Clearinghouse.

The director of the Agency for Healthcare Research and Quality (AHRQ), discusses AHRQ's efforts to eliminate central line-associated blood stream infections. A key part of this effort is the implementation of the Comprehensive Unit-based Safety Program, which has now been extended to 46 states.

## Upcoming Events

**IPRO HAI Webinars** [www.ipro.org/index/hai-pe](http://www.ipro.org/index/hai-pe)

Tuesday, July 9 • 1:00 PM EST: **PCR Testing**

Wednesday, September 18 • 7:00AM EST: **Review of the SSI prevention best practices**

Thursday, September 19 • 1:00 PM EST: **National HAI Virtual Conference**



<http://hai.ipro.org>

**IPRO's online portal to information and resources on HAI prevention**

- Tools and articles by infection prevention and patient safety experts,
- Information on dates and times for upcoming webinars,
- Recorded webinars, and presentations,
- Patient education materials,
- and more.

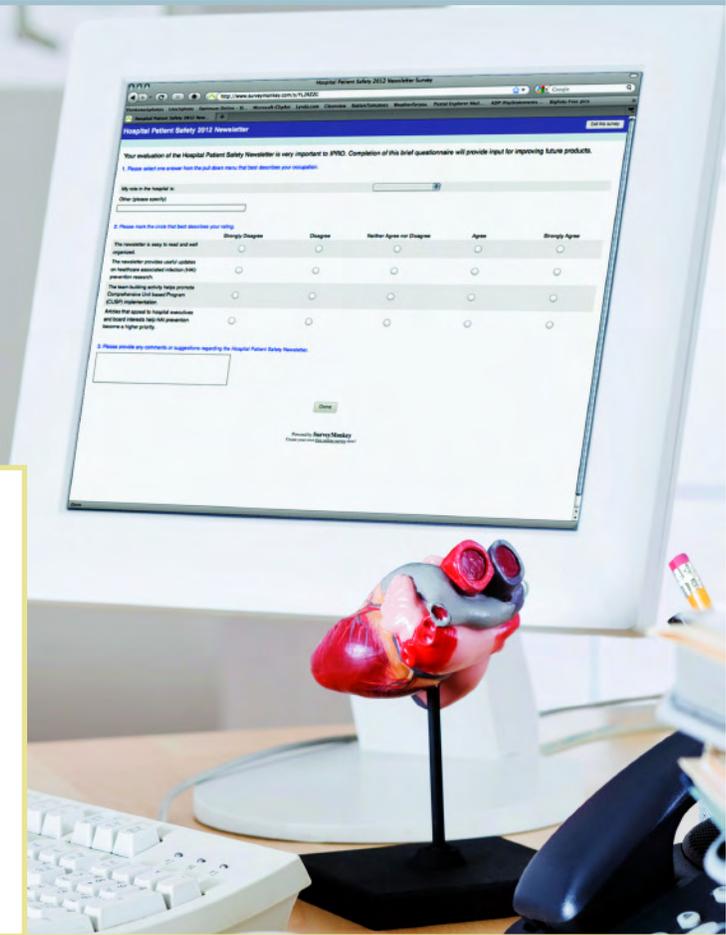
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## About IPRO

Through its work as the Medicare Quality Improvement Organization for New York State, IPRO works to improve the quality of healthcare provided to more than three million Medicare beneficiaries. An independent, not-for-profit organization, IPRO supports providers across the state with evidence-based, clinical interventions and objective expertise to improve patient care.

For more information about IPRO, please visit [www.ipro.org](http://www.ipro.org).

## The Hospital Patient Safety Staff at IPRO

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